Centers for Medicare & Medicaid Services (CMS)

Standard Companion Guide Transaction Information

Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated005010X220A1 addenda for the Federally facilitated Exchange (FFE)

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1 Introduction

This Companion Guide to the v5010 Accredited Standards Committee (ASC) X12N Implementation Guides and associated errata adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the Federally facilitated Health Insurance Exchange via the Data Services Hub. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

This Companion Guide is based on, and must be used in conjunction with, the ASC X12 X12N/005010X220 Type 3 Technical Report (TR3) and its associated A1 addenda. The Companion Guide clarifies and specifies specific transmission requirements for exchanging data with the Federally facilitated Health Insurance Exchange via the Data Services Hub. The instructions in this companion guide conform to the requirements of the TR3, ASC X12 syntax and semantic rules and the ASC X12 Fair Use Requirements. In case of any conflict between this Companion Guide and the instructions in the TR3, the TR3 takes precedence.

Express consent for this use of ASC X12 copyrighted materials has been granted.

1.1 Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). On March 30, 2010, the President signed into law the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA creates new competitive private health insurance markets – called Health Insurance Exchanges (Exchanges) – that provide millions of Americans and small businesses access to affordable coverage and the same insurance choices as members of Congress. Exchanges help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans that fit their needs at competitive prices.

The Act and subsequent Rule outline the standards to be used between the Exchange and covered entities. The Exchange is required to use the standards, implementation specifications, operating rules, and code sets adopted by the Secretary in 45 CFR parts 160 and 162. Further, the Exchange is required to incorporate interoperable and secure standards and protocols developed by the Secretary in accordance with section 3021 of the Public Health Service (PHS) Act.

This companion guide contains detailed information about how the Federally facilitated Exchanges (FFE) will use the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda.

1.2 Companion Guides

Companion guides (CG) are documents created to supplement ASC X12 Type 3 Technical Reports (TR3). TR3s, commonly known as Implementation Guides (IG), define the data content and format for specific business purposes. This CG was created for distribution to health care issuers, clearinghouses, and software vendors. The instructions in this CG are not intended to

be stand-alone requirements, the CG must be used in conjunction with the ASC X12/005010X220 Benefit Enrollment and Maintenance (834) TR3 and its associated A1 Addenda. ASC X12 TR3s are copyrighted documents and may be purchased at http://store.x12.org.

1.3 Other Resources

Table 1 - Other Resources provides Web Sites that contain additional information and documentation for adopted Electronic Data Interchange (EDI) transactions and code sets.

The Websites provided in Table 1 contain additional information and documentation for adopted Electronic Data Interchange (EDI) transactions and code sets.

Table 1 - Other Resources

Resource	Web Address
ASC X12 TR3 Implementation Guides	http://store.x12.org
Washington Publishing Company Health Care Code Sets	http://www.wpc-edi.com/reference/
To request changes to HIPAA adopted standards	http://www.hipaa-dsmo.org/
CMS Implementation Guide for the Federally-facilitated Exchange and Data Services Hub	https://zone.cms.gov/home

2 Getting Started

In order to send and/or receive transactions from the FFE, Trading Partners (clearinghouses, qualified health plan issuers (QHP issuers) and State-Based Exchanges (SBEs)) must complete a trading partner agreement, exchange profile information and establish connectivity. The following sections outline the steps.

2.1 Trading Partner Profile

Establishing a Trading Partner Profile is a simple process, the Trading Partner completes and signs a Trading Partner Agreement form and submits it to the Hub team for processing. Electronic Data Interchange (EDI) interface should be set up and tested with the Trading Partner. The first step that the Hub team will take is to establish Trading Partner Profile(s).

The Hub team will configure a test profile for one or more EDI interfaces with the Trading Partner. A Trading Partner with multiple data centers must acquire multiple Trading Partner Profiles. Once the EDI interface(s) have been successfully tested, the Hub team will notify the FFE to open the Trading Partner's Qualified Health Plan (QHP) for enrollment and will switch the Trading Partner Profile to a production status.

3 Testing

Syntax Integrity and Syntax Requirement specifications must be met in order for 834 transactions to be processed in a production mode. The Hub team will work with Trading Partners (clearinghouses, QHP Issuers and SBEs) throughout the testing process.

3.1 Testing Overview

Testing is conducted to ensure compliance with HIPAA guidelines as related to:

- Syntactical integrity: EDI files must pass verification checks related to valid segment use, segment order, element attributes, proper transmission of numeric values, validation of ASC X12 syntax, and compliance with ASC X12 rules.
- Syntactical requirements: EDI files must be validated for compliance with HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts and the use of qualifiers, codes, elements and segments. Testing will also verify intra-segment situational data elements, non-medical code sets and that values and codes are used according to the Implementation Guide instructions.

It's important to know additional testing may be required when the system is upgraded, when business requirements change, or when new versions of the ASC X12 834 implementation guide are implemented.

3.2 Testing Process

Trading Partners may call the eXchange Operational Support Center (XOC) in Contact Information Section below for help at any point in the testing process outlined below.

1. The Trading Partner downloads the 834 Companion Guides and Trading Partner Enrollment package from www.cms.zone.gov for approved Issuers and State Based Markets via the approved State Officer.
2. The Trading Partner completes and signs the Trading Partner Agreement and submits the signed agreement to Hub team.
3. The Hub team coordinates the linkage between the Trading Partner Submitter Identifier, User Logon Identifier and password and notifies the Trading Partner.
4. The Hub team provides a limited number of initial test files to the Trading Partner for processing. The Trading Partner downloads the files via Secure File Transfer Protocol (SFTP).
5. The Trading Partner processes the files through their validation process and reports any failure via acknowledgement transaction.
6. If all the test files pass cleanly through the validation process, the Trading Partner submits a confirmation 834 to the Hub via SFTP.
7. The FFE validates the confirmation 834 and reports any issues via an acknowledgement transaction.
8. If the confirmation 834 is successfully validated, the test is considered successful and the trading partner is approved to begin processing in the production environment.
9. If issues or errors are identified in steps 4, 5, 6 or 7, the test is not considered successful and the Hub team and Trading Partner work together until the issues are resolved and a successful test is completed.

4 Connectivity

Trading Partners will connect to the Hub for exchange of EDI transactions (enrollment, acknowledgement, payment, etc.) via the CMS Enterprise File Transfer (EFT) system which is a batch system. Real-time transmissions are not available at this time.

Each Trading Partner is assigned a Submitter Identifier in the EFT system which allows access to a mailbox. The Trading Partner and the Hub will use this mailbox to pick up and drop off data files.

The Enterprise File Transfer (EFT) Supplement, available at CMS Technical Reference Architecture, defines the enterprise-wide standard architecture for transferring files between CMS data centers as well as between CMS data centers and external partners.

4.1 Transmission Specifics

4.1.1 Delimiters

The Exchange is not establishing a requirement or preference for delimiters on inbound transactions. See Table B.5 in Appendix B.1.1.2.5 of the TR3 for ASC X12's requirements related to delimiters.

4.1.2 Control Numbers

The Exchange is not establishing specific requirements for the ISA, and GS control numbers, other than a rule that at least one of the control numbers must increment from one day to the next. However, the ST control number must be numeric. While the ASC X12C 005010X231 Implementation Acknowledgement for Health Care Insurance (999) transaction does not reflect the ISA control number, we strongly recommend that one or both of the GS and ST control numbers increment from day to day.

4.1.3 Hub Processing Capabilities

The Hub can accept multiple:

- Physical files in multiple submissions in one day.
- ISA-IEA envelopes within a single physical file.
- GS-GE envelopes within a single ISA-IEA interchange.
- ST-SE envelopes within a single GS-GE functional group.
  - A physically grouped set of Acknowledgment transactions (e.g. TA1 and 999 in one physical file)
- Members (2000 loop) within a single ST-SE transaction.

4.1.4 File Rejection Reasons

The entire logical structure contained within a physical submission will be rejected in the following situations:

- Submission of data that is not valid based on the TR3.
- Submission of a segment or data element specified in the TR3 as “Not Used”.
- Submission of non-unique values in the ST02 or GS06 Control Number elements.

4.1.5 Control Characters Support

See Appendix B of any ASC X12 Technical Report Type 3 (TR3) for support of the Control Character for more information related to the Basic Character Set and the Extended Character Set. The Federal Data Services HUB supports the Extended Character Set in order to properly send items such as email addresses which require the “@” character in the data element of the PER segment.

5 Contact Information

Trading Partners that need to interact with the Level One Help Desk shall be able to contact the eXchange Operational Support Center (XOC) at the following number and email address:

Telephone: 1-855-CMS-1515

Email: CMS_FEPS@cms.hhs.gov

Hours of Operation: 9:00 am – 5:00 pm Eastern

Any correspondence received during off hours at the email address above is addressed the next business morning.

6 FFE Enrollment (834) Transaction Flows

6.1 Overview of Eligibility and Enrollment Activities

The Affordable Care Act (P.L. 111-148 and 111-152) allows each State the opportunity to establish an Affordable Insurance Exchange ("Exchange") to help individuals and small employers purchase affordable health insurance coverage. Coverage through the Exchange will begin in every State on January 1, 2014, with enrollment beginning October 1, 2013. Recognizing that not all States may elect to establish a State-based Exchange by this statutory deadline, the Affordable Care Act directs the Secretary of HHS to establish and operate an FFE in any State that does not elect to do so, or will not have an operable Exchange for the 2014 coverage year.

6.1.1 The Data Services Hub (Hub) and Eligibility and Enrollment Transactions

The Hub is a single interface for the States and federal partners (e.g., Social Security Administration, Department of Homeland Security, Internal Revenue Service, et al) which facilitates the information exchange and business functionality in support of Health Insurance Exchange operations. The Hub ensures adherence to federal and industry standards regarding security, data transport, and information safeguards management. The Hub streamlines and simplifies the information flows between States and federal agencies. The Hub will facilitate the exchange of 834 transactions between the parties as described in this companion guide. Specifically, the hub will serve as the gateway for enrollment transactions between the FFE and QHP issuers that offer coverage through the FFE, and will also accept copies of enrollment transactions sent by SBEs to QHP issuers that offer coverage through SBEs, for the purposes of enabling Federal payments of advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR), preventing duplicate APTC across multiple Exchanges, and performance measurement. The Hub will facilitate the exchange of 834 transactions between the parties as described in this companion guide.

6.1.2 Centers for Medicare and Medicaid Services (CMS) Enterprise File Transfer (EFT) System

QHP Issuers and other EDI trading partners will connect to the Hub (for enrollment and/or financial management EDI transactions) via the CMS Enterprise File Transfer (EFT) system which is a batch system. Each QHP Issuer is assigned a Submitter Identifier (Secure Point of Entry – SPOE) in the EFT system which allows access to a mailbox. The QHP Issuer and the Hub use this mailbox to pick up and drop off data files.

6.2 FFE to QHP Issuer 834 Transaction Flow

The FFE will send the first 834 transaction to a QHP Issuer(s) with enrollment information; this exchange contains the Initial Enrollment Notification transaction(s). This transaction is created after an application has been determined eligible and a Qualified Health Plan (QHP) selected.

The Trading Partner will return an Enrollment Effectuation Confirmation 834. This effectuation confirmation transaction will contain information assigned by the QHP Issuer and be stored within the FFE data store.

Other 834 uses detailed in this companion guide include cancellations, terminations, reinstatements and changes to existing health coverage enrollments.

Figure 1 outlines the high level steps and interactions between the FFE, Hub, and QHP Issuers and other trading partners.

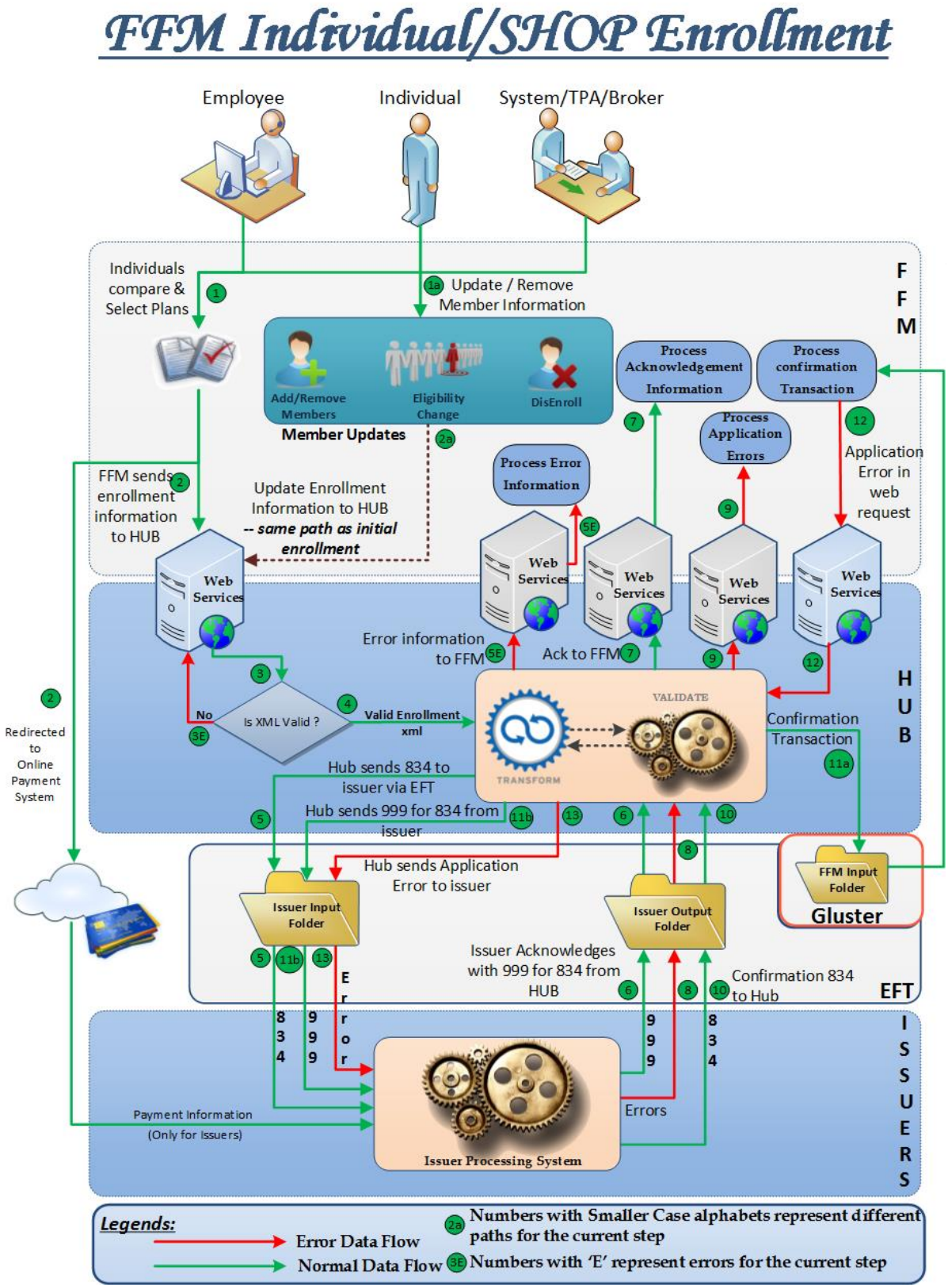


Figure 1 - 834 Transaction Flow

6.3 Transaction Flow

The SBE will send the first 834 transaction to the HHS with enrollment information; this exchange contains the Initial Enrollment Notification transaction(s). This transaction is created after an application has been determined eligible and a Qualified Health Plan (QHP) selected. The SBE enrollment data sent to HHS will be stored in the Federal Exchange Program System (FEPS) Enrollment Data Store (EDS).

Once enrollment has been effectuated the SBE will send an Enrollment Effectuation Confirmation 834. This effectuation confirmation transaction will contain information assigned by the QHP Issuer.

7 Control Segments/Envelopes

This section identifies the qualifiers the FFE will send in the outer envelopes.

7.1 ISA Segment

The transmission envelope must be created according to the instructions in the 005010X220 TR3. In accordance with those instructions, FFE will send, and prefers to receive, the qualifiers outlined in Table 2 - ISA Segment Instructions

Table 2 - ISA Segment Instructions

Segment	Reference	Name	Code	Exchange Instruction
ISA - Interchange Control Header Segment	ISA01	Authorization Information Qualifier	00	
	ISA03	Security Information Qualifier	00	
	ISA05	Interchange ID Qualifier	ZZ	
	ISA06	Interchange Sender ID	CMSFFM	For outbound transactions
	ISA07	Interchange ID Qualifier	ZZ	
	ISA08	Interchange Receiver ID		
	ISA14	Acknowledgment Requested	1	
Note: When trading partners are sending transactions to the HUB, e.g. inbound to the HUB, they are required to reverse the values in ISA06 and ISA08 as noted above for the outbound transaction from the HUB				

7.2 GS Segment

The Functional Group envelope must be created according to the instructions in the 005010X220 TR3. In accordance with those instructions, FFE will send, and prefers to receive, the qualifiers outlined in *Table 3 - GS Segment Instructions*.

Table 3 - GS Segment Instructions

Segment	Reference	Name	Code	Exchange Instruction
GS – Functional Group Header Segment	GS02	Application Sender's Code		For outbound transactions from the HUB this will be the Tennant ID (e.g. 2 character State Abbreviation Code and one numeric value (zero),
	GS03	Application Receiver's Code		For outbound transactions from the HUB this is the 14 characters of the Qualified Health Plan Identifier (QHPID).
Note: When trading partners are sending transactions to the HUB, e.g. inbound to the HUB, they are required to reverse the values in GS02 and GS03 as noted above for the outbound transaction from the HUB				

8 Acknowledgements

The Hub expects to receive a TA1 acknowledgement for every outbound interchange in which an ASC X12 005010 834 transaction set is sent.

The Hub expects to receive a 999 acknowledgement for every functional group in every outbound 834 file sent.

The Hub will send a TA1 acknowledgement for every inbound interchange received.

The Hub will send a 999 acknowledgement for every inbound functional group in every inbound 834 file received.

9 FFE Specific Business Rules and Limitations

This section contains design rules and other helpful information used as transaction requirements were developed.

9.1 Identifying the Member in 834 Transmissions

An Exchange enrollee, also referred to as a qualified individual, has a number of different identifiers within the Exchange. These enrollee identifiers are transmitted in loop 2000 REF segments in 834 transmissions, with a specific Reference Identification Qualifier associated with each use. Table 4 describes the various enrollee identifiers and their associated qualifier. In addition, the enrollee's SSN, if available, is transmitted in the NM1 segment on the initial enrollment transactions but is not included in maintenance transactions between the FFE and QHP Issuer.

Table 4 - All Other FFE Outbound Transaction Identifiers

Member Identifier	Ref ID Qualifier	Notes
Exchange Assigned ID	0F	When transmitted in the Subscriber Identifier REF **Note**: 10 numeric characters placed in the Alphanumeric field. No check digits, no intelligence is found in the characters
Issuer Assigned Subscriber ID	ZZ	When transmitted in the Member Supplemental Identifier REF
Exchange Assigned Member ID	17	Transmitted in the Member Supplemental Identifier REF **Note:** See the Exchange Assigned ID describing formatting
Issuer Assigned Member ID	23	Transmitted in the Member Supplemental Identifier REF
Exchange Assigned Policy ID[1]	1L	When Transmitted in the 2300 Health Coverage Policy Number REF. NOTE: When the FFM is sending the "Cancel" or "Termination" for the entire Enrollment Group the 2000 level REF shall contain the "1L" qualifier for the Exchange Assigned Policy ID.

9.2 General Business Rules

- The FFE shall create explicit transactions identified by Maintenance Type and Maintenance Reason Codes for Add, Change, Cancellation or Termination purpose.
- Dates must be explicitly transmitted, they cannot be assumed.
- An inconsistency period starts on the date of determination, not the date of enrollment
- An enrollment group consists of all individuals enrolled and linked by the policy exchange identifier.

[1] When the FFM is generating the FFM "Exchange Assigned Policy ID" the data element definition is numeric with a minimum length of 1 digits and maximum length of 15 digits. When the SBE sends the SBE "Exchange Assigned Policy ID" to the Federal Data Services HUB, this data element can be up to 46 alphanumeric characters.

Note: Other individuals may be linked by the policy exchange identifier such as custodial parent, but may not be considered part of the enrollment group. The policy exchange identifier is a number that links together the individuals within an enrollment group that are enrolled in a qualified health plan under a subscriber. The Enrollment Group is exchanged with the FFM in a single transaction (ST-SE) 834 configuration for all FFM and SBE information entering the Federal Data Services Hub.

- When there is a change in circumstance, eligibility re-determination must be completed for every member of the enrollment group before the enrollment group can be terminated.
- A Cancellation Transaction is generated when the enrollment is to be ended with no actual coverage. A cancellation can happen any time prior to the effective date of the initial coverage.
- A Termination Transaction is generated when the enrollment is to be terminated after the effective date. The enrollee was covered by the QHP Issuer for some period of time.
- United States addresses sent shall conform to the guidelines established by the United States Postal Service (USPS).
- In the FF_SHOP only, a Group Enrollment XML document shall be sent prior to any actual Benefit Enrollment and Maintenance (834) transaction. The generation of these documents shall be sent to the FF-SHOP issuers during weekday business and not be sent during the weekend off-hours. This will allow for proper set up by issuers before the 834 traffic in order to prevent out of sequence processing and should reduce the need for retransmission of the X12 834 transactions.
- Table 5 outlines the situation when a member obtains coverage for multiple products.

Table 5 - Sample for Multiple Policy (Medical & Dental) information in an 834 Transaction

Medical Coverage	Dental Coverage
GS*xx0*QHPID…	GS*xx0*QHPID…
ST	ST
Table 1 – Header Information	Table 1 – Header Information
Table 2 – Detail	Table 2 – Detail
Subscriber – John Anyman	Subscriber – John Anyman
2000 – Member Level Detail	2000 – Member Level Detail
INS – Member Level Detail	INS – Member Level Detail
REF – Subscriber Identifier	REF – Subscriber Identifier
REF – Member Supplemental Identifier	REF – Member Supplemental Identifier
DTP – Member Level Dates	DTP – Member Level Dates
2100A – Member Name	2100A – Member Name
NM1 – Member Name	NM1 – Member Name
PER – Member Communication Numbers	PER – Member Communication Numbers
N3 – Member Residence, Street Address	N3 – Member Residence, Street Address
N4 – Member City, State, ZIP code	N4 – Member City, State, ZIP code
DMG – Member Demographics	DMG – Member Demographics
HLH – Member Health Information	HLH – Member Health Information
LUI – Member Language (if applicable)	LUI – Member Language (if applicable)
2100C – Member Mailing Address (If applicable)	2100C – Member Mailing Address (If applicable)
2300 – Health Coverage	2300 – Health Coverage
HD – Health Coverage - Medical	HD – Health Coverage - Dental
DTP – Health Coverage Dates	DTP – Health Coverage Dates
REF – Health Coverage Policy Number	REF – Health Coverage Policy Number
LS	LS
2700 – Member Reporting Categories	2700 – Member Reporting Categories
LX – Member Reporting Categories	LX – Member Reporting Categories
2750 – Reporting Category	2750 – Reporting Category
N1 – Reporting Category	N1 – Reporting Category
REF – Reporting Category Reference	REF – Reporting Category Reference
DTP – Reporting Category Date	DTP – Reporting Category Date
LE	LE
SE	SE
GE	GE

Note: One ASC X12 834 Transaction Set (ST-SE) consists of only one Enrollment Group.

9.3 Enrollment Business Rules

- Enrollment periods are considered “open ended” until a triggering event results in an end to the individual’s enrollment with a QHP.
- An **Enrollment Period End Date** is not sent on initial enrollment transactions.
- An **Enrollment Period End Date** is sent when cancelling or terminating an enrollment period.
- Except for initial enrollments, the old enrollment must always be terminated with an end date before a new enrollment can be processed.
- Communication Contacts. The implementation guide limits the number of member communication contacts that can be sent to 3.
  - Communication contacts for the FF-SHOP market will be sent in the following order:
    - Primary Phone (TE)
    - Secondary Phone (AP)
    - Email (EM)
  - Communication contacts for the Individual Market will be sent in the following order:
    - Primary Phone (TE)
    - Secondary Phone (AP)
    - Preferred Communication Method (EM for email or BN for text message), either an email address or phone number for receiving text messages. If no preferred communication method chosen, the 3rd communication contact will not be sent.
- Member Health Information (HLH), Health Related Code (HLH01). Information about tobacco use will be sent on every initial enrollment transaction. The three valid responses a QHP Issuer may receive are:
  - “N” No Tobacco Use, if indicated with QHP selection
  - “T” Tobacco Use, if indicated with QHP selection
  - “U” Unknown Tobacco Use, if not “N” or “T”

9.4 Premium Business Rules

APTC is paid at the subscriber level for an enrollment group. In general, will only begin on the first of the month but can be terminated mid-month. APTC eligibility is a requirement for CSR, EXCEPT for Native Americans. So, it may be rare to see CSR without APTC although an individual who is eligible for APTC can select an actual APTC of $0 in which case he or she can still be eligible for CSR.

CSR is paid at the subscriber level for an enrollment group. This is the amount the QHP Issuer can expect to receive as the advance CSR payment. This amount is depicted at the subscriber level for the enrollment group.

Note: The CMS approved Per Member Per Month (PMPM) advance CSR payment amount must be totaled for the enrollment group. Example: PMPM amount for 73% CSR silver plan variation ($10) x 4 members in enrollment group = $40 Advance CSR payment amount depicted in this segment at the subscriber level.

Financial Changes require two 834 transactions to be exchanged. The first 834 transaction shall result in the update of the “End Date” information. The second 834 transactions shall have a new “Effective Date”, Financial amounts and “End Date” information is not required

Table 6 - 834 Transaction Financial Changes

Financial Amount Changed	First Transaction Effective Start Date	First Transaction Effective End Date	Second Transaction Effective Start Date	Second Transaction Effective End Date
APTC AMT[2]	Y	Y	Y	N
CSR AMT[3]	Y	Y	Y	N
PRE AMT 1	Y	Y	Y	N
TOT PRE AMT	Y	Y	Y	N
TOT RES AMT	Y	Y	Y	N
PRE AMT TOT	Y	Y	Y	N
TOT EMP RES AMT[4]	Y	Y	Y	N
Rating Area	Y	Y	Y	N

9.4.1 Individual Market and FF-SHOP Market Dependent Status for WARD within the 834

For the Individual and FF-SHOP Market

- The Marketplace will identify disabled dependents with the relationship code of “ward.”
- The Marketplace identifies wards when we ask consumers via the eligibility application about the relationships between applicants. We provide help text to indicate that disabled dependents should be identified as wards.
- Eligible subscriber-dependent relationships were collected from issuers in the business rules section of the QHP application. Ward is an option. Business rules can be updated during Plan Preview
- When the FFM/FF-SHOP sends an enrollment transaction to the issuer that includes a ward exceeding the maximum dependent age, the issuer can presume that that dependent is an overage disabled dependent.
- If an issuer’s own internal policies or state rules require keeping an overage disabled dependent on the same policy, and the issuer did not submit “ward” as an eligible relationship in QHP business rules, we ask that the issuer resubmit business rules to add “ward.”

[2] Only present on Financial Change Transactions when this information pertains to the Enrollment Group. If not present for the Enrollment group before the Financial Change Transaction occurs, then it is NOT sent in either of the two 834 Financial Change transaction
[3] Only present on Financial Change Transactions when this information pertains to the Enrollment Group. If not present for the Enrollment group before the Financial Change Transaction occurs, then it is NOT sent in either of the two 834 Financial Change transaction
[4] SHOP ONLY Financial Change Transactions

9.5 Individual and SHOP Market Rate Calculations

The following subsections outline the Market Rate Calculations within ASC X12 834 used in the Individual and SHOP markets. Specifically, the premium payment elements, their definitions and the calculations used to derive their values within the FFE created 834 transactions.

9.5.1 Individual Market Rate Calculations within the 834

Table 7 - Individual Market, Individually Rated Definitions and Calculations contains premium payments elements, their definitions and the calculations used to derive their values within the FFE 834 created transactions for the individual market.

Table 7 - Individual Market, Individually Rated Definitions and Calculations

Premium Payment	834 - 2750 Member Reporting Category Name
Rating Area. The rating area used to determine the premium amounts.	RATING AREA Subscriber Only
Premium Amount. Individual member rated portion of the premium if the plan is individually rated. The total of all individual premiums should equal the premium amount total. If the plan is family rated, this qualifier will not be sent.	PRE AMT 1 Every member (i.e., every enrollment record)
Premium Amount Total. The Exchange derives the total premium amount by adding all individual member premium amounts (PRE AMT 1). This is also the amount the QHP Issuer can expect to receive from all payment sources for the enrollment group. PRE AMT TOT = Sum of all PRE AMT 1 for the enrollment group	PRE AMT TOT Subscriber Only
Other Payer Amounts. The amount the QHP Issuer can expect to receive from a Federally recognized Tribe to pay a portion of the total premium amount. (This segment will only be utilized by some SBMs in 2014).	OTH PAY AMT 1 Subscriber Only
Other Payer Amounts. The amount the QHP Issuer can expect to receive from the State to pay a portion of the total premium amount. (This segment will only be utilized by some SBMs in 2014).	OTH PAY AMT 2 Subscriber Only
Advance Payment of the Premium Tax Credit (APTC) Amount. The amount the QHP Issuer can expect to receive as the amount of actual APTC toward the total premium amount.	APTC AMT Subscriber Only
Total Responsibility Amount owed by the enrollment group (the amount the covered individuals owe toward the total premium amount) TOT RES AMT = + PRE AMT TOT - APTC AMT - OTH PAY AMT 1 - OTH PAY AMT 2	TOT RES AMT Subscriber Only

Table 8 - Individual Market, Family Rated Definitions and Calculations contains premium payments elements, their definitions and the calculations used to derive their values within the FFE 834 created transactions.

Table 8 - Individual Market, Family Rated Definitions and Calculations

Premium Payment	834 - 2750 Member Reporting Category Name
Rating Area. The rating area used to determine the premium amounts.	RATING AREA Subscriber Only
Premium Amt Total. This is the family rated total premium amount as determined by the Exchange. It is also the amount the QHP Issuer can expect to receive from all payment sources for the enrollment group	PRE AMT TOT Subscriber Only
Other Payer Amounts. The amount the QHP Issuer can expect to receive from a Federally recognized Tribe to pay a portion of the total premium amount. (This segment will only be utilized by some SBMs in 2014).	OTH PAY AMT 1 Subscriber Only
Other Payer Amounts. The amount the QHP Issuer can expect to receive from the State to pay a portion of the total premium amount. (This segment will only be utilized by some SBMs in 2014).	OTH PAY AMT 2 Subscriber Only
Advance Payment of the Premium Tax Credit (APTC) Amount. The amount the QHP Issuer can expect to receive as the actual APTC toward the total premium amount.	APTC AMT Subscriber Only
Total Amt owed by the Enrollment Group (the amount the covered individuals owe toward the total payment amount) TOT RES AMT = + PRE AMT TOT - APTC AMT - OTH PAY AMT 1 - OTH PAY AMT 2	TOT RES AMT Subscriber Only

9.5.2 SHOP Market Rate Calculations within the 834

Table 9 - SHOP Market, Individually Rated Definitions and Calculations contains premium payments elements, their definitions and the calculations used to derive their values within the FFE 834 created transactions for the SHOP market.

Table 9 - SHOP Market, Individually Rated Definitions and Calculations

Premium Payment	834 - 2750 Member Reporting Category Name
Rating Area. The rating area used to determine the premium amounts.	RATING AREA Subscriber Only
Premium Amount Individual member rated portion of the premium if the plan is individually rated. The total of all individual premiums should equal the premium amount total. If the plan is family rated, this qualifier will not be sent.	PRE AMT 1 Every member (i.e., every enrollment record)

Premium Payment	834 - 2750 Member Reporting Category Name
Premium Amount Total. The Exchange derives the total premium amount by adding all individual member premium amounts (PRE AMT 1). This is also the amount the QHP Issuer can expect to receive from all payment sources for the enrollment group. PRE AMT TOT = + Sum of all PRE AMT 1 for the enrollment group	PRE AMT TOT Subscriber Only
Total Employer Responsibility Amount. The Amount the employer will pay against the total premium amount.	TOT EMP RES AMT Subscriber Only
Amount owed by the Enrollment Group (the amount the covered individuals owe toward the total premium amount) TOT RES AMT = + PRE AMT TOT - TOT EMP RES AMT	TOT RES AMT Subscriber Only

9.6 2700 Member Reporting Categories Loop

The FFE has defined a number of Member Reporting Categories, and associated information, that must be transmitted in various 834 transmissions. For easy reference, the next two subsections describe the Individual Marketplace and the SHOP Marketplace. When there is no information to be sent, for example, the individual does not qualify for APTC, then the segment(s) are not to be transmitted.

9.6.1 Individual Market: 2750 Reporting Categories Loop

Table 10and Table 11 summarize all the categories defined for transmission in the Individual Market of any 2750 Reporting Category Loop. The required categories are also included in the instruction section for each applicable business use. Please note that these Member Reporting Categories MAY be sent in some and MUST be sent in others. For example, if a new enrollee was not eligible for APTC, the APTC amount will not be included on the outbound initial enrollment transaction, but is listed here as a “Y” because it could be sent on an initial enrollment. A second example is; Confirmation Transactions MUST include the Member Reporting Category loop, “ADDL MAINT REASON” with the code value of “CONFIRM.”

Table 10 - The Individual Member Reporting Category Loop

To transmit this Information	N102 Value	REF01 Value	REF02 Data	DTP Y/N	Init Enroll	Confirm Enroll	CAN	TERM	CHG
Additional Maintenance Reason (reason category)		17	The specific reason code, see below						
Cancellation (cancellation category)	"ADDL MAINT REASON"	17	"CANCEL" or "CANCEL-FLC" or "CANCEL-MDC" or "CANCEL-CHP" or "CANCEL-NLE" or "CANCEL-MEC" See additional Maintenance Reason Codes definitions below for further information	Y			Y		
Confirmation (confirmation category)	"ADDL MAINT REASON"	17	"CONFIRM"	Y		Y			
Change (change category)	"ADDL MAINT REASON"	17	"FINANCIAL CHANGE"	Y					Y
Change (change category)	"ADDL MAINT REASON"	17	"CSR CHANGE"	Y					Y
Termination (termination category)	"ADDL MAINT REASON"	17	"TERM", or "TERM-FRD" or "TERM-FLC" or "TERM-MDC" or "TERM-CHP" or "TERM-NLE" or "TERM-MEC" or "TERM-DCT" See additional Termination Maintenance Reason Codes definitions below for further information	Y				Y	

Additional Cancelation and Termination Maintenance Reason Codes

- FRD[5] – Fraud: Members committing fraud/misrepresentation
- FLC - Free Look Cancellation: Enrollment Group is cancelled as requested during state free look period
- MDC - Newly eligible for Medicaid: Members becoming eligible for Medicaid once in FFM
- CHP - Newly eligible for CHIP Members becoming eligible for CHIP once in FFM
- NLE - No Longer Eligible for coverage: Incarceration, unlawful presence, etc.
- MEC - Enrollee obtaining other Minimum Essential Coverage: Someone becoming newly employed with health benefits.
- DCT – QHP Is Decertified or Terminated: The FFM declares a QHP no longer qualified so all enrollment groups must be terminated or transitioned to another Certified QHP

Table 11 - The Individual Member Reporting Category Loop (continued)

To transmit this Information									
	N102 Value	REF01 Value	REF02 Data	DTP Y/N	Init Enroll	Confirm Enroll	CAN	TERM	CHG
Another payment amount (payment category)	"OTH PAY AMT 1"	9V	NNNNNNNN.NN This amount is the Tribal payment amount toward the Total Premium Amount.	Y	Y	Y			Y
Another payment amount (payment category)	"OTH PAY AMT 2"	9V	NNNNNNNN.NN This amount is the State payment toward the Total Premium Amount.	Y	Y	Y			Y
APTC amount (APTC category) NOTE: Sent when the member qualifies for APTC. If the member has elected no APTC amount, then zero shall be transmitted.	"APTC AMT"	9V	NNNNNNNN.NN This is the amount the QHP Issuer can expect to receive as the amount of actual APTC toward the Total Premium Amount.	Y	Y	Y			Y

[5] Not Used for "CANCEL" Maintenance Reason Code processing.

To transmit this Information									
	N102 Value	REF01 Value	REF02 Data	DTP Y/N	Init Enroll	Confirm Enroll	CAN	TERM	CHG
CSR amount (CSR amount category) NOTE: Sent when the member qualifies for CSR. If the member does not qualify then no CSR amount shall be sent.	"CSR AMT"	9V	NNNNNNNN.NN This is the advance CSR Payment Amount.	Y	Y	Y			Y
Premium amount (premium category)	"PRE AMT 1"	9X	NNNNNNN N.NN For individual rated coverage, this is the individual premium rate.	Y	Y	Y			Y
Time Stamp when the user actually submits his application for enrollment	"REQUEST SUBMIT TIMESTAMP"	17	CCYYMMDDHHMMSS		Y	Y	Y	Y	Y
Rating area used to determine premium amounts. (premium category)	"RATING AREA"	9X	R- XX999 – where XX is the State Abbreviation Code and 999 represents the numerical value assigned (between 001 and 150) for the area. This is the rating area used in determining the individual or family premium amounts.	Y	Y	Y			Y
Source Exchange ID (source category)	"SOURCE EXCHANGE ID"	17	This is the Source Exchange ID. This is the Tennant ID a two character State Abbreviation and a single numeric character of 0 (zero).	Y	Y	Y	Y	Y	Y

To transmit this Information									
	N102 Value	REF01 Value	REF02 Data	DTP Y/N	Init Enroll	Confirm Enroll	CAN	TERM	CHG
Application Generation ID and Insurance Application Origin Type **Note:** Currently FF-SHOP only. Shall be applied to the FFM application during summer of 2014	"APPLICATION ID AND ORIGIN"	6M	XXXXXXXXXXXXXXX - X Where the Application ID is 1-15 alpha numeric and the Origin is 1 alpha numeric. This is the value for the Application ID from either the FFM User Interface or the Direct Enrollment User Interface used to generate the Enrollment. The Application Origin is the source of the application information.	N	Y	Y	Y	Y	Y
Special Enrollment Period Reason (SEP category)	"SEP REASON"	17	This is the reason for the Special Enrollment Period	Y	Y	Y			
Total individual responsibility amount (payment category)	"TOT RES AMT"	9V	NNNNNNN N.NN This is the Total Amt owed by the enrollment group (the amount the covered individuals owe toward the total premium amount).	Y	Y	Y			Y
Total premium for the health coverage sent at the subscriber level. (premium category)	"PRE AMT TOT"	9X	NNNNNNN N.NN This is the total amount the QHP Issuer can expect to receive from all payment.	Y	Y	Y			Y

9.6.2 SHOP Market: 2750 Member Reporting Categories Loop

Table 12 summarizes all the categories defined in the SHOP Market of any 2750 Reporting Category Loop. The required categories are also included in the instruction section for each applicable business use. Please note that these Member Reporting Categories MAY be sent in some and MUST be sent in others. For example, a new dependent enrollee will not include the TOT RES AMT, but is listed here as a "Y" because it will be sent on an initial enrollment for the subscriber. A second example is; Confirmation Transactions MUST include the Member Reporting Category loop, "ADDL MAINT REASON" with the code value of "CONFIRM."

Table 12 - The SHOP Member Reporting Category Loop

To transmit this Information									
	N102 Value	REF01 Value	REF02 Data	DTP Y/N	Init Enroll	Confirm Enroll	CAN	TERM	CHG
Additional Maintenance Reason (reason category)		17	The specific reason code, see below						
Cancellation (cancellation category)	"ADDL MAINT REASON"	17	"CANCEL" or "CANCEL-FLC" or "CANCEL-MEC" See additional Maintenance Reason Codes definitions below for further information.	Y			Y		
Confirmation (confirmation category)	"ADDL MAINT REASON"	17	"CONFIRM"	Y		Y			
Termination (termination category)	"ADDL MAINT REASON"	17	"TERM" or "TERM-FRD" or "TERM-FLC" or "TERM-DCT" See additional Maintenance Reason Codes definitions below for further information.	Y				Y	

To transmit this Information									
	N102 Value	REF01 Value	REF02 Data	DTP Y/N	Init Enroll	Confirm Enroll	CAN	TERM	CHG
Change (change category)	"ADDL MAINT REASON"	17	"FINANCIAL CHANGE"	Y					Y
Premium amount (premium category)	"PRE AMT 1"	9X	NNNNNNN N.NN For individual rated coverage, this is the individual premium rate.	Y	Y	Y			Y
Rating area used to determine premium amounts. (premium category)	"RATING AREA"	9X	R-XX999. where XX is the State Abbreviation Code and 999 represents the numerical value assigned (between 001 and 150) for the area. This is the rating area used in determining the individual or family premium amounts.	Y	Y	Y			Y
Source Exchange ID (source category)	"SOURCE EXCHANGE ID"	17	This is the Source Exchange ID. This is the Tennant ID a two character State Abbreviation and a single numeric character of 0 (zero).	Y	Y	Y	Y	Y	Y

To transmit this Information									
	N102 Value	REF01 Value	REF02 Data	DTP Y/N	Init Enroll	Confirm Enroll	CAN	TERM	CHG
Application Generation ID and Origin **Note:** Currently FF-SHOP only. Shall be applied to the FFM application during summer of 2014	"APPLICATION ID AND ORIGIN"	6M	XXXXXXXXXXXXXXX-X Where the Application ID is 1-15 alpha numeric and the Origin is 1 alpha numeric. This is the value for the Application ID from either the FFM User Interface or the Direct Enrollment User Interface used to generate the Enrollment. The Application Origin is the source of the application information.	N	Y	Y	Y	Y	Y
SHOP Smoking Cessation Indicator	"SHOP ONLY-CESSATION" **Note:** Only used for FF-SHOP	XX1	This information will be included on any Subscriber or Member who has indicated enrollment into the Plan smoking cessation program	Y	Y	Y			Y
Special Enrollment Period Reason (SEP category)	"SEP REASON"	17	This is the reason for the Special Enrollment Period	Y	Y	Y			
Total individual responsibility amount (payment category)	"TOT RES AMT"	9V	NNNNNNN N.NN This is the Total Amt owed by the enrollment group (the amount the covered individuals owe toward the total premium amount).	Y	Y	Y			Y

To transmit this Information									
	N102 Value	REF01 Value	REF02 Data	DTP Y/N	Init Enroll	Confirm Enroll	CAN	TERM	CHG
Total employer responsibility amount (payment category)	"TOT EMP RES AMT"	9V	NNNNNNN N.NN This is the total employer responsibility amount to be paid by the Employer for the employee and any of the employee dependents.	Y	Y	Y			Y
Total premium for the health coverage sent at the subscriber level. (premium category)	"PRE AMT TOT"	9X	NNNNNNN N.NN This is the total amount the QHP Issuer can expect to receive from all payment.	Y	Y	Y			Y

Additional Cancelation and Termination Maintenance Reason Codes

- FRD[6] – Fraud: Members committing fraud/misrepresentation
- FLC - Free Look Cancellation: Enrollment Group is cancelled as requested during state free look period
- DCT – QHP Is Decertified or Terminated: The FFM declares a QHP no longer qualified so all enrollment groups must be terminated or transitioned to another Certified QHP

Table 13 - Special Enrollment Period Reason Codes

Position	Code Value	Code Value Description
REF02		
	07-TERMINATION OF BENEFITS	Qualified Individual (QI) or dependent loss of Minimum Essential Coverage (MEC)
	32-MARRIAGE	QI gains or becomes a dependent due to marriage
	02-BIRTH	QI gains or becomes a dependent due to birth
	05-ADOPTION	QI gains or becomes a dependent due to adoption or placement of adoption
	ER-EXCHANGE ERROR	QI enrollment or non-enrollment in a QHP is the result of an Exchange ERROR

[6] Not Used for "CANCEL" Maintenance Reason Code processing.

Position	Code Value	Code Value Description
	43-CHANGE OF LOCATION **NOTE:** FF-SHOP Only	New QHPs available due to a permanent move
	EX-EXCEPTIONAL CIRCUMSTANCES	Exceptional Circumstances

Table 14 - Special Enrollment Period Examples

Special Enrollment Period	
Example 1:	**Example 2:**
INS*Y*18*021*EC*A***AC~ … N1*75*SEP REASON~ REF*17*32-MARRIAGE ~ DTP*RD8*20140317-20140515~	INS*Y*18*021*EC*A***AC~ … N1*75*SEP REASON~ REF*17* EX-EXCEPTIONAL CIRCUMSTANCES ~ DTP*RD8*20140317-20140515~

9.6.3 Federally Facilitated Race and Ethnicity Code Set Crosswalk

The following information provides the crosswalk of Race and Ethnicity as used in the FFM On-line Application process and then as this information is cross-walked to the DMG05 repeating data element in the ASC X12 005010X220A1 Technical Report Type 3.

When a FFM is receiving Enrollment transactions from the State Based Exchanges (SBE), the SBE can elect to only use the values found in the TR3 for DMG05-1 or they can follow the convention described for Race or Ethnicity used in the FFM On-Line.

A total of ten (10) race and/or ethnicity codes can be sent. See the Tables below for the detailed information for Race or Ethnicity. The number of each is determined by the consumer's online choices.

Table 15 - Ethnicity Codes

Ethnicity	
Choices for the FFM Application On-Line Selection	**CDC Code Sent on 834**
Hispanic, Latino or Spanish Origin	2135-2
Not Hispanic	2186-5
Cuban	2182-4
Mexican, Mexican American, or Chicano/a	No Code, Default to 2148-5
Puerto Rican	2180-8

Ethnicity	
Choices for the FFM Application On-Line Selection	**CDC Code Sent on 834**
Other	No Code, No Default, ignore on the 834

Table 16 - Race Codes

RACE	
Choices for the FFM Application On-Line Selection	**CDC Code Sent on 834**
American Indian or Alaskan Native	1002-5
Asian Indian	2029-7
Black or African American	2054-5
Chinese	2034-7
Filipino	2036-2
Guamanian or Chamorro	2086-7
Japanese	2039-6
Korean	2040-4
Native Hawaiian	2079-2
Other Asian	2131-1
Other Pacific Islander	2500-7
Samoan	2080-0
Vietnamese	2047-9
White	2106-3
Other	2131-1

10 DETAILED 834 INFORMATION BY BUSINESS USE

The information in this section applies to both individual and SHOP segment markets, except where noted.

10.1 Initial Enrollment Instructions - FFE to QHP Issuer

An Initial Enrollment transmission is created by the Exchange and sent to the QHP Issuer after an application has been determined eligible and a QHP has been selected.

Transmissions will be created according to the instructions in the 005010X220 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements, additional information specific to the FFE implementation is outlined in Table 17below.

Table 17 - 834 Supplemental Instructions for Initial Enrollment

Loop	Reference	Name	Code	Exchange Instruction
HEADER	BGN	Beginning Segment		
	BGN08	Action Code	2	
	QTY	Transaction Set Control Totals		
	QTY01	Quantity Qualifier	TO DT ET	FFM and FF-SHOP will always transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set FFM and FF-SHOP will transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set with INS01 = N when the number exceeds zero. FF-SHOP only will transmit to indicate that the value conveyed in QTY02 represents the total number of INS segments in this ST/SE set with INS01 = Y. This number will represent the number of Employee Subscribers contained in the transaction Set.
1000A	N1	Sponsor Name	FI 24 94	Individual market: identifies the subscriber from the enrollment group, unless the subscriber is under-aged. If the subscriber is under-aged, identifies the responsible person. FF-SHOP market: identifies the employer Tax ID

Loop	Reference	Name	Code	Exchange Instruction
1000B	N1	Payer	FI XV	Per TR3 this value is available for Health Plans prior to the HPID Rule implementation, but will remain available for no-HPID organization post HPID rule date Will transmit “XV” after the HPID is required.
1000C	N1	TPA/Broker		Identifies the TPA/Broker associated with the enrollment.
	N101		BO	FFM user Interface will transmit the TPA/Broker ID as the National Producer Number (NPN) and data element N101 shall be “BO”.
	N102			Individual market: The FFM user Interface will transmit the name as entered in the on-line screen (Agent or broker). FF-SHOP market: will appear as first name + space + last name. The last name will be truncated if the total length is greater than 60 characters.
	N103		94	FFM user Interface will transmit the TPA/Broker ID as the National Producer Number (NPN) and data element N101 shall be “BO”.
	N104			FFM user Interface will transmit the number of the Agent or broker as entered in the on-line screen (NPN number).
1100C	ACT	TPA/Broker Account Information		Will never be transmitted.
2000	INS	Member Level Detail		
	INS02	Individual Relationship Code		The value 18 must be used for the subscriber. For dependents; this value identifies their relationship to the subscriber.
	INS03	Maintenance Type Code	021	
	INS04	Maintenance Reason Code	EC	Will transmit when the member has selected a QHP.
	INS06	Medicare Status Code		

Loop	Reference	Name	Code	Exchange Instruction
	INS06-1	Medicare Plan Code	D	Individual market: this data element will never be transmitted. FF-SHOP market: will transmit “D” when individual is also covered by Medicare.
	INS08	Employment Status Code	AC AC, RT	Individual market: will transmit “AC” for the Initial Enrollment transactions. FF-SHOP market: will transmit “AC” or “RT” for the Initial Enrollment transactions.
2000	REF	Subscriber Identifier		
	REF02			Will transmit the Exchange Assigned Identifier See Subscriber definition in Acronyms/Glossary For detailed information.
2000	REF	Member Supplemental Identifier		
	REF01	Reference Identification Qualifier	17 6O	Will transmit when the Exchange Assigned Member ID will be conveyed in REF02. Will transmit a Payment Transaction ID in REF02. The format shall be XX99999999999, where XX represents the State Abbreviation Code and 11 numeric digits.
2100A	NM1	Member Name		
	NM109	Member Identifier		The SSN is allowed for this Federally administered program based on confidentiality regulations. Will transmit the member’s SSN, when known on the Initial Enrollment Transaction only.
2100A	PER	Member Communications Numbers		Will transmit three communication contacts, when the information is available. Refer to Section 9.3.
2100A	N4	Member City, State, ZIP Code		

Loop	Reference	Name	Code	Exchange Instruction
	N406	Location Identifier		For Individual market: will transmit County of Residence. See http://www.itl.nist.gov/fipspubs/fip6-4.htm FIPS PUB 6-4 Supersedes FIPS PUB 6-3 1979 December 15 For further detail. Examples: New York City is 36061 Baltimore City is 24510 For FF-SHOP market: this data element will never be sent.
2100A	DMG	Member Demographics		.
	DMG04	Marital Status Code		Individual market: will transmit the marital status for the subscriber. FF-SHOP market: this data element will never be sent.
2100A	EC	Employment Class		Additional employment class information will never be transmitted.
2100A	ICM	Member Income		Member income information will never be transmitted.
2100A	AMT	Member Policy Amount		Member Policy Amount information will never be transmitted.
2100A	HLH	Member Health Information		Only information about tobacco use will be transmitted.
2100A	LUI	Member Language		Transmission of this information is required when known and allowed. Member language information will be transmitted on the subscriber record when known.
2100B		Incorrect Member Name Loop		This loop does not apply to initial enrollments.
2100D		Member Employer Loop		This loop will never be transmitted.
2100E		Member School Loop		This loop will never be transmitted.

Loop	Reference	Name	Code	Exchange Instruction
2100F		Custodial Parent Loop		Individual market: since minors are subscribers in their own right, custodial parent information will always be sent for minor subscribers when available during the on-line application processing. If not available during the Application creation, this information is not sent for the Enrollment process FF-SHOP market: this loop will never be transmitted.
2100G		Responsible Person Loop		Individual market: the Custodial Parent loop and the Responsible Person loop may both be transmitted for an enrollment. FF-SHOP market: this loop will never be transmitted.
2100G	NM1	Responsible Person		
	NM101	Entity Identifier Code		Will transmit “QD” or “S1” as appropriate. Will be sent for Tribal Sponsors (“QD”) and (“S1”) for minor subscribers when available during the on-line application processing. If not available during the Application creation, this information is not sent for the Enrollment process
2100G	PER	Responsible Person Communication Numbers		Will never be transmitted.
2100H	NM1	Drop-Off Location		This loop will never be transmitted.
2200		Disability Information		This loop will never be transmitted.
2300	HD	Health Coverage		
	HD03	Insurance Line Code	HLT DEN	Will transmit coverage information for the qualifiers shown, as applicable.
	HD05	Coverage Level Code		This data element will never be sent.
2300	DTP	Health Coverage Dates		.
	DTP03	Coverage Period	348	The actual enrollment begin date must be transmitted. Enrollment into the QHP is not effectuated until the initial premium has been paid.
2300	REF	Health Coverage Policy Number		

Loop	Reference	Name	Code	Exchange Instruction
	REF01	Reference Identification Qualifier	CE	QHP ID Purchased is the Assigned Plan Identifier (standard component identifier) plus the Variation Component. See Assigned Qualified Health Plan Identifier (QHP) in Acronyms/Glossary For detailed information.
	REF01	Reference Identification Qualifier	1L	Will transmit when the Exchange Assigned Policy Identifier will be conveyed in the associated REF02 element. This is a numerically defined value with a length of 1-15.
2300	REF	Prior Coverage Months		Prior Coverage Months information will never be transmitted.
2300	REF	Identification Card		Identification Card information will never be transmitted.
2310		Provider Information Loop		This loop will never be transmitted.
2320		Coordination of Benefits Loop		This loop will never be transmitted.
2330		Coordination of Benefits Related Entity		This loop will never be transmitted.
2700		Member Reporting Categories		This loop will be transmitted when additional premium category reporting is appropriate. See Section 9.6 for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.)
2750	N1	Reporting Category		See Section 9.6.1 and Section 9.6.2 for a complete list of Reporting Categories.

10.2 Enrollment Confirmation / Effectuation Instructions – QHP Issuer to FFE

An Enrollment Effectuation/Confirmation transmission is created by the QHP Issuer and sent to the Hub when the Initial Enrollment transaction is successfully processed. Except where overruled by the usage requirements of the 005010X220 TR3, QHP Issuers must return all the information transmitted on the Initial Enrollment Transaction in addition to the information detailed below. An example of a TR3 usage rule superseding the instruction to return information as received is BGN03, which must reflect the creation date of the Enrollment Effectuation Confirmation transaction and not the Initial Enrollment's creation date.

For each Initial Enrollment transaction an Enrollment Confirmation/Effectuation transaction is returned upon receipt of payment. An Initial Enrollment transaction is defined when data element INS03 - Maintenance Type Code contains the value of "021 – Addition" and the data element INS04 - Maintenance Reason Code contains the value "EC - Member Benefit Selection" or "41 – Re-enrollment" For each Initial Enrollment transaction, an Enrollment

Confirmation/Effectuation transaction is returned to the FFM upon receipt of payment for Initial Payment.

Transmissions must be created according to the instructions in the 005010X220 TR3, along with any ASC X12 published Errata documentation, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 18 below.

Table 18 - 834 Supplemental Instructions for Confirmation/Effectuation

Loop	Reference	Name	Code	Exchange Instruction
HEADER	QTY	Transaction Set Control Totals		If the transaction set control totals sent with the Initial Enrollment transaction are not accurate for this confirmation/effectuation, transmit accurate totals instead of the values received in the Initial Enrollment file.
	QTY01	Quantity Qualifier	TO DT ET	The total is required for all transactions. Dependent total is required for all transactions. Employee total is required for FF-SHOP transactions
2000	INS	Member Level Detail		
	INS04	Maintenance Reason Code	28	Transmit when the QHP Issuer has effectuated member coverage
2000	REF	Member Supplemental Identifier		
	REF01	Reference Identification Qualifier	23 ZZ	Transmit with the QHP Issuer Assigned Member ID conveyed in REF02. Transmit with the QHP Issuer Assigned Subscriber ID conveyed in REF02. **Note:** These two QHP Issuer assigned Identifiers must be returned on all the Confirmation/Effectuation Transactions
2100B		Incorrect Member Name Loop		Member information may not be corrected in an effectuation/confirmation transmission. Do not transmit this loop.
2300	DTP	Health Coverage Dates		Individual market: Three iterations are required. FF-SHOP market: One iteration is required.
	DTP03	Coverage Period	348	The actual enrollment begin date must be transmitted. Enrollment into the QHP is not effectuated until the initial premium has been paid.

Loop	Reference	Name	Code	Exchange Instruction
	DTP03	Coverage Period	343	Individual market: The Premium Paid to Date End must be transmitted for the subscriber. **Note:** Transaction will not reject if this information is sent for every member of the enrollment group, but it is required for the subscriber. FF-SHOP market: not expected to be transmitted.
	DTP03	Coverage Period	543	Individual market: The Last Premium Paid Date must be transmitted for the subscriber. **Note:** Transaction will not reject if this information is sent for every member of the enrollment group, but it is required for the subscriber. FF-SHOP market: not expected to be transmitted.
2300	REF	Health Coverage Policy Number		
	REF01	Reference Identification Qualifier	X9	Transmit with the QHP Issuer assigned Health Coverage Purchased Policy Number conveyed in REF02. **Note:** The QHP Issuer assigned Policy Identifier must be returned on all the Confirmation/Effectuation Transactions.
			E8	Transmit when the QHP Issuer assigned Employer Group Number is conveyed in REF02. **Note:** The QHP Issuer assigned Employer Group Number must be returned on all FF-SHOP Confirmation/Effectuation Transactions.
2700		Member Reporting Categories		This loop will be transmitted when additional premium category reporting is appropriate. See Section 9.6 for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.)
2750	N1	Reporting Categories		See Section 9.6.1 and Section 9.6.2 for a complete list of Reporting Categories.
	N102	Member Reporting Category Name		"ADDL MAINT REASON"

Loop	Reference	Name	Code	Exchange Instruction
	REF	Reporting Category Reference		
	REF01	Reference Identification Qualifier	17	
	REF02	Member Reporting Category Reference ID		"CONFIRM"

10.3 Individual Market and FF-SHOP Cancellation Instructions – QHP Issuer to FFE/FF-SHOP, FFE/FF-SHOP to QHP Issuer

Unlike the preceding transactions, the Cancellation transaction may be initiated by either the FFE/FF-SHOP or the QHP Issuer. Cancellation transactions are not required to include all information transmitted in the Initial Enrollment and Confirmation/Effectuation transactions.

As indicated in Section 9.2 above, a Cancellation transaction is generated when the enrollment is to be ended with no actual coverage. A cancellation can happen any time. The Cancellation transaction shall remove the entire Enrollment Group and coverage. The Member Level Dates DTP01 with a value of "357 – Eligibility End" shall not be prior to the Enrollment date sent in the Initial Enrollment transaction for the Enrollment Coverage was never in effect.

The FFE/FF-SHOP will send a Cancellation transaction to the QHP Issuer when coverage is cancelled prior to the effective date of enrollment. A cancellation should result in no coverage for any period of time. One example for the usage of a Cancellation transaction from the FFE to the QHP Issuer would be a result of an enrollee participating in a Free Look Period (FLP) then notifying the FFE that he or she wishes to terminate his or her enrollment in a QHP.

For Individual market, QHP Issuers will send a Cancellation transaction to the FFE when the initial premium payment was not timely.

A Cancellation transaction from the QHP Issuer to the FFE/FF-SHOP will result in the health coverage being cancelled for the entire enrollment group.

Further, when a QHP Issuer is sending cancellation information for an Enrollment group that has coverage for both Medical and Dental polices, it must be clear which coverage type is being Cancelled. This shall accomplished by sending either the Issuer Assigned Policy Number or the Exchange Assigned Policy Number (2000 Level REF01 equals 1L).

Transmissions must be created according to the instructions in the 005010X220 TR3, along with any ASC X12 published Errata documentation, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE/FF-SHOP Implementation is outlined in Table 19 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

Table 19 - 834 Supplemental Instructions for Individual and FF-SHOP Market Cancellation

Loop	Reference	Name	Code	Exchange Instruction
2000	INS	Member Level Detail		
	INS04	Maintenance Reason Code	59 14	QHP Issuer to FFE: This qualifier must be used when the reason for Cancelation is non- payment of premium. FFE to QHP Issuer:.
	INS08	Employment Status Code	TE TE, AC, or RT	Individual market: will transmit “TE” for termination transactions. FF-SHOP market: will transmit “TE”, “AC”, or “RT” for cancellation transactions.
2000	REF	Subscriber Identifier		
	REF02			Will transmit the Exchange Assigned Identifier See Subscriber definition in Acronyms/Glossary For detailed information.
2000	REF	Member Policy Number		
	REF02			The QHP Issuer Assigned Policy ID. Or The Exchange Assigned Policy ID when the QHP Issuer Assigned is not available.
2000	REF	Member Supplemental Identifier		Transmit the IDs shown below when they were present on the initial enrollment.
	REF01	Reference Identification Qualifier	17 23 ZZ	When the Exchange Assigned Member ID will be conveyed in REF02. When the QHP Issuer Assigned Member ID will be conveyed in REF02. When the QHP Issuer Assigned Subscriber ID will be conveyed in REF02.
2000	DTP	Member Level Dates		
	DTP03	Status Information Effective Date	357	The eligibility end date of the cancellation must match the benefit begin date sent on the initial enrollment.

Loop	Reference	Name	Code	Exchange Instruction
2700		Member Reporting Categories		This loop will be transmitted when additional premium category reporting is appropriate. See Section 9.6 for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.)
2750	N1	Reporting Categories		See Section 9.6.1 and Section 9.6.2 for a complete list of Reporting Categories.
	N102	Member Reporting Category Name		"ADDL MAINT REASON"
	REF	Reporting Category Reference		
	REF01	Reference Identification Qualifier	17	
	REF02	Member Reporting Category Reference ID		"CANCEL"

10.4 Individual Market Termination Instructions – QHP Issuer to FFE/FF-SHOP, FFE/FF-SHOP to QHP Issuer (Entire Enrollment Group)

Like the cancellation transactions, the Termination transaction may be initiated by either the FFE/FF-SHOP or the QHP Issuer. Termination transactions are not required to include all information transmitted in the Initial Enrollment and Confirmation/Effectuation transactions.

As indicated in Section 9.2 above, a Termination Transaction is generated when the enrollment is to be terminated after the effective date. The enrollee was covered by the QHP Issuer for some period of time.

The FFE/FF-SHOP will send a Termination transaction to the QHP Issuer for a variety of reasons. An enrollee has coverage for a period of time before the termination ends the coverage. For example, an enrollee may choose to be terminated for moving out of the QHP service area.

QHP Issuers will send a Termination transaction to the FFE when a premium payment was not timely. FF-SHOP will send a termination transaction to QHP Issuer when a premium payment was not timely. This transaction will result in the health coverage being terminated for the entire enrollment group. QHP Issuer grace period policies must meet applicable state and federal requirements for grace periods.

Transmissions must be created according to the instructions in the 005010X220 TR3, along with any ASC X12 published Errata documentation, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 20 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

Table 20 - 834 Supplemental Instructions for Individual and FF-SHOP Market Termination

Loop	Reference	Name	Code	Exchange Instruction
2000	INS	Member Level Detail		
	INS04	Maintenance Reason Code	59 14	QHP Issuer to FFE: This qualifier must be used when the reason for termination is non- payment of premium. FFE to QHP Issuer
	INS08	Employment Status Code	TE TE, AC, or RT	Individual market: will transmit “TE” for termination transactions. FF-SHOP market: will transmit “TE”, “AC”, or “RT” for termination transactions.
2000	REF	Subscriber Identifier		
	REF02			Will transmit the Exchange Assigned Identifier See Subscriber definition in Acronyms/Glossary For detailed information.
2000	REF	Member Policy Number		
	REF02			The QHP Issuer Assigned Policy ID. Or The Exchange Assigned Policy ID when the QHP Issuer assigned is not available.
2000	REF	Member Supplemental Identifier		Transmit the IDs shown below when they were present on the initial enrollment.
	REF01	Reference Identification Qualifier	17 23 ZZ	When the Exchange Assigned Member ID will be conveyed in REF02. When the QHP Issuer Assigned Member ID will be conveyed in REF02. When the QHP Issuer Assigned Subscriber ID will be conveyed in REF02.
2000	DTP	Member Level Dates		
	DTP03	Status Information Effective Date	357	The eligibility end date of the termination must be transmitted.

Loop	Reference	Name	Code	Exchange Instruction
2700		Member Reporting Categories		One iteration is required for all Terminations. See Section 9.6 for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.)
2750	N1	Reporting Categories		See Section 9.6.1 and Section 9.6.2 for a complete list of Reporting Categories.
	N102	Member Reporting Category Name		"ADDL MAINT REASON"
	REF	Reporting Category Reference		
	REF01	Reference Identification Qualifier	17	
	REF02	Member Reporting Category Reference ID		"TERM", or "TERM-FRD" or "TERM-FLC" or "TERM-MDC" or "TERM-CHP" or "TERM-NLE" or "TERM-MEC" or "TERM-DCT" See additional Termination Maintenance Reason Codes definitions below for further information

Additional Termination Maintenance Reason Codes

- FRD - Fraud: Members committing fraud/misrepresentation
- FLC - Free Look Cancellation: Enrollment Group is cancelled as requested during state free look period
- MDC[7] - Newly eligible for Medicaid: Members becoming eligible for Medicaid once in FFM
- CHP[8] - Newly eligible for CHIP Members becoming eligible for CHIP once in FFM
- NLE[9] - No Longer Eligible for coverage: Incarceration, unlawful presence, etc.
- MEC - Enrollee obtaining other Minimum Essential Coverage: Someone becoming newly employed with health benefits.
- DCT - QHP Is Decertified or Terminated: The FFM declares a QHP no longer qualified so all enrollment groups must be terminated or transitioned to another Certified QHP

[7] Not used in FF-SHOP
[8] Not used in FF-SHOP
[9] Not used in FF-SHOP

10.5 Individual and SHOP Market Termination Instructions – FFE/FF-SHOP to QHP Issuer Terminate Individual(s) from an Enrollment Group

Termination transactions for one or more individuals for an Enrollment Group shall only be initiated by the FFE/FF-SHOP.

As indicated in Section 9.2 above, a Termination Transaction is generated when the enrollment is to be terminated after the effective date. The enrollee was covered by the QHP Issuer for some period of time.

The FFE/FF-SHOP will send a Termination transaction to the QHP Issuer for a variety of reasons. An enrollee has coverage for a period of time before the termination ends the coverage. For example, an enrollee that has moved out of the QHP Service area may choose to be terminated. The individuals being terminated shall be included at the 2300 Health Coverage Loop when this situation occurs.

Transmissions must be created according to the instructions in the 005010X220A1 TR3, along with any ASC X12 published Errata documentation, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 21 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

Table 21 - 834 Supplemental Instructions for Individual and FF-SHOP Market Termination

Loop	Reference	Name	Code	Exchange Instruction
2000	INS	Member Level Detail		
	INS03	Maintenance Type Code	024	
	INS04	Maintenance Reason Code		The appropriate Maintenance Reason Code will be sent for the transaction being created.
2000	REF	Subscriber Identifier		
	REF02			Will transmit the Exchange Assigned Identifier See Subscriber definition in Acronyms/Glossary For detailed information.
2000	REF	Member Supplemental Identifier		Transmit the IDs shown below..

Loop	Reference	Name	Code	Exchange Instruction
	REF01	Reference Identification Qualifier	17 23 ZZ	When the Exchange Assigned Member ID will be conveyed in REF02. When the QHP Issuer Assigned Member ID will be conveyed in REF02. When the QHP Issuer Assigned Subscriber ID will be conveyed in REF02.
2300	HD	Health Coverage		
	HD01	Maintenance Type Code	024	
	HD05	Coverage Level Code		This data element will never be sent.
2300	DTP	Health Coverage Dates		
	DTP03	Status Information Effective Date	349	The benefit end date
2300	REF	Health Coverage Policy Number		
	REF01	Reference Identification Qualifier	CE	QHP ID Purchased is the Assigned Plan Identifier (standard component identifier) plus the Variation Component. See Assigned Qualified Health Plan Identifier (QHP) in Acronyms/Glossary For detailed information.
	REF01	Reference Identification Qualifier	E8	Individual market: will never be transmitted. FF-SHOP market: Will transmit when the Employer Group Number will be conveyed in the associated REF02 element.
	REF01	Reference Identification Qualifier	1L	Will transmit when the Exchange Assigned Policy Identifier will be conveyed in the associated REF02 element. This is a numerically defined value with a length of 1-15.
	REF01	Reference Identification Qualifier	X9	Will transmit when the Issuer Assigned Policy Identifier will be conveyed in the associated REF02 element.
2700		Member Reporting Categories		One iteration is required for all Terminations. See Section 9.6 for a complete list of Reporting Categories. (Note: The use of the 2700 LS, 2700 LX & LE follows the base TR3.)

Loop	Reference	Name	Code	Exchange Instruction
2750	N1	Reporting Categories		See Section 9.6.1 and Section 9.6.2 for a complete list of Reporting Categories.
	N102	Member Reporting Category Name		"ADDL MAINT REASON"
	REF	Reporting Category Reference		
	REF01	Reference Identification Qualifier	17	
	REF02	Member Reporting Category Reference ID		"TERM or "TERM-FRD" or "TERM-MDC" or "TERM-CHP" or "TERM-NLE" or "TERM-MEC" See additional Termination Maintenance Reason Codes definitions below for further information

Additional Termination Maintenance Reason Codes

- FRD - Fraud: Members committing fraud/misrepresentation
- MDC[10] - Newly eligible for Medicaid: Members becoming eligible for Medicaid once in FFM
- CHP[11] - Newly eligible for CHIP Members becoming eligible for CHIP once in FFM
- NLE[12] - No Longer Eligible for coverage: Incarceration, unlawful presence, etc.
- MEC - Enrollee obtaining other Minimum Essential Coverage: Someone becoming newly employed with health benefits.

10.6 Other Transaction Instructions - FFE to QHP Issuer

This section describes a number of enrollment transactions that are patterned after the Initial Enrollment.

[10] Not used in FF-SHOP
[11] Not used in FF-SHOP
[12] Not used in FF-SHOP

10.6.1 Individual Market – Re-enrollment, FFE to QHP Issuer

A Re-enrollment transaction is generated when an enrollee who has been terminated needs to be re-enrolled. A potential reason for this transaction would be when the subscriber is no longer eligible and the remaining members of the enrollment group need to be re-enrolled under a new subscriber. In this situation, the previous QHP Issuer assigned subscriber identifier will be conveyed as a member supplemental identifier.

Except as noted in the table below, the Reinstatement transaction will contain all the information transmitted on the Initial Enrollment Transaction.

Transmissions must be created according to the instructions in the 005010X220 TR3, along with any ASC X12 published Errata documentation, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 22 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

Table 22 - 834 Supplemental Instructions for Individual Market – Re-enrollment

Loop	Reference	Name	Code	Exchange Instruction
2000	INS	Member Level Detail		
	INS04	Maintenance Reason Code	41	
	INS08	Employment Status Code	AC	
2000	REF	Member Supplemental Identifier		Transmit the IDs shown below when they were present on the initial enrollment.
	REF01	Reference Identification Qualifier	Q4	When the Previous QHP Issuer Assigned Subscriber ID will be conveyed in REF02.

10.6.2 SHOP Market – Reinstatements, FFE-SHOP to QHP Issuer

A Reinstatement transaction is generated when an enrollee who has been cancelled or terminated needs to be reinstated. A potential reason for this transaction would be when an employer group falls behind in payment and then makes full payment within policy timeframes. All employees would have been terminated for non-payment of premium. They are being added back using the reinstatement maintenance type code.

Except as noted in the table below, the Reinstatement transaction will contain all the information transmitted on the Initial Enrollment Transaction.

Transmissions must be created according to the instructions in the 005010X220 TR3, please refer to that TR3 for a complete understanding of 834 transmission requirements. Additional information specific to the FFE implementation is outlined in Table 23 below. These instructions apply to 834 transactions regardless of who initiates the transaction.

Table 23 - 834 Supplemental Instructions for FF-SHOP Market Reinstatement

Loop	Reference	Name	Code	Exchange Instruction
2000	INS	Member Level Detail		
	INS03	Maintenance Type Code	025	Reinstatement maintenance type code will be transmitted.
	INS04	Maintenance Reason Code	41	Reinstatement is the FFE-SHOP equivalent to the ASC X12 term Re- enrollment.
	INS08	Employment Status Code	AC or RT	
2300	HD	Health Coverage		
	HD01	Maintenance Type Code	025	Reinstatement maintenance type code must be transmitted.

10.6.3 Change in Circumstance – FF-SHOP only

The FFE will send three transactions to the QHP Issuer when a change in circumstance results in a new enrollment during the month. One example would be an enrollment for a newborn. This enrollment results in a change in initial enrollment for the newborn and a financial change transaction (ending/closing out the amounts for a period) and a new financial change transaction (with the new financial amounts).

The first transaction will be the initial enrollment transaction adding the new individual to the enrollment group.

The second transaction (end-dates the old financial amounts, including premium), INS03 will contain "001", INS04 will be blank, and the 2750 REF02 Member Reporting Category Reference ID will contain "FINANCIAL CHANGE."

The third transaction (adds the 'new' financial amounts with just an effective date), INS01 will contain "001", INS04 will be blank, and the 2750 REF02 Member Reporting Category Reference ID will contain "FINANCIAL CHANGE."

10.6.4 Address Change which does not require a change in QHP Enrollment

The FF-SHOP will send one transaction to the QHP Issuer when a change of address does not result in a QHP termination.

10.6.5 Address Change which does require a change in QHP Enrollment

The FF-SHOP will send two transactions to the QHP Issuer when a change of address results in a QHP termination. Two transactions will be created and sent, the first transaction will be the change of address and the second the termination.

10.7 Monthly Reconciliation File Processes

The exchange rule requires that a QHP Issuer reconcile enrollment files with the exchange no less than once a month and that the exchange reconcile enrollment information with QHP Issuers and HHS no less than on a monthly basis. These separate processes are discussed below in the following sections.

10.7.1 Reconciliation File - FFE to QHP Issuer

The FFE will have completed all daily operational activities related to enrollment before initiating monthly reconciliation with QHP Issuers. Next the FFE will extract the membership information to be transmitted to the QHP issuer from the Enrollment Data Store (EDS) and format the outbound 834 Monthly enrollment transaction set to be sent to the QHP Issuer, based upon the same selection criteria the QHP Issuer will create the 834 file to be sent to the FFE for comparison purposes. The information from the two files will then be compared. The comparison process will produce a list of discrepancies (aka delta information, or differences). This information will then be made available to the FFE Reconciliation Contractor for follow-up.

The has the ability to perform the same function within their own operating environment by comparing the data received from the FFE via the monthly 834 and their own extracted data. The differences or delta can then be confirmed with the FFE Reconciliation Contractor.

Figure 2 outlines the high level steps and interactions for the reconciliation process that takes place between the FFE, Hub, and QHP Issuers.

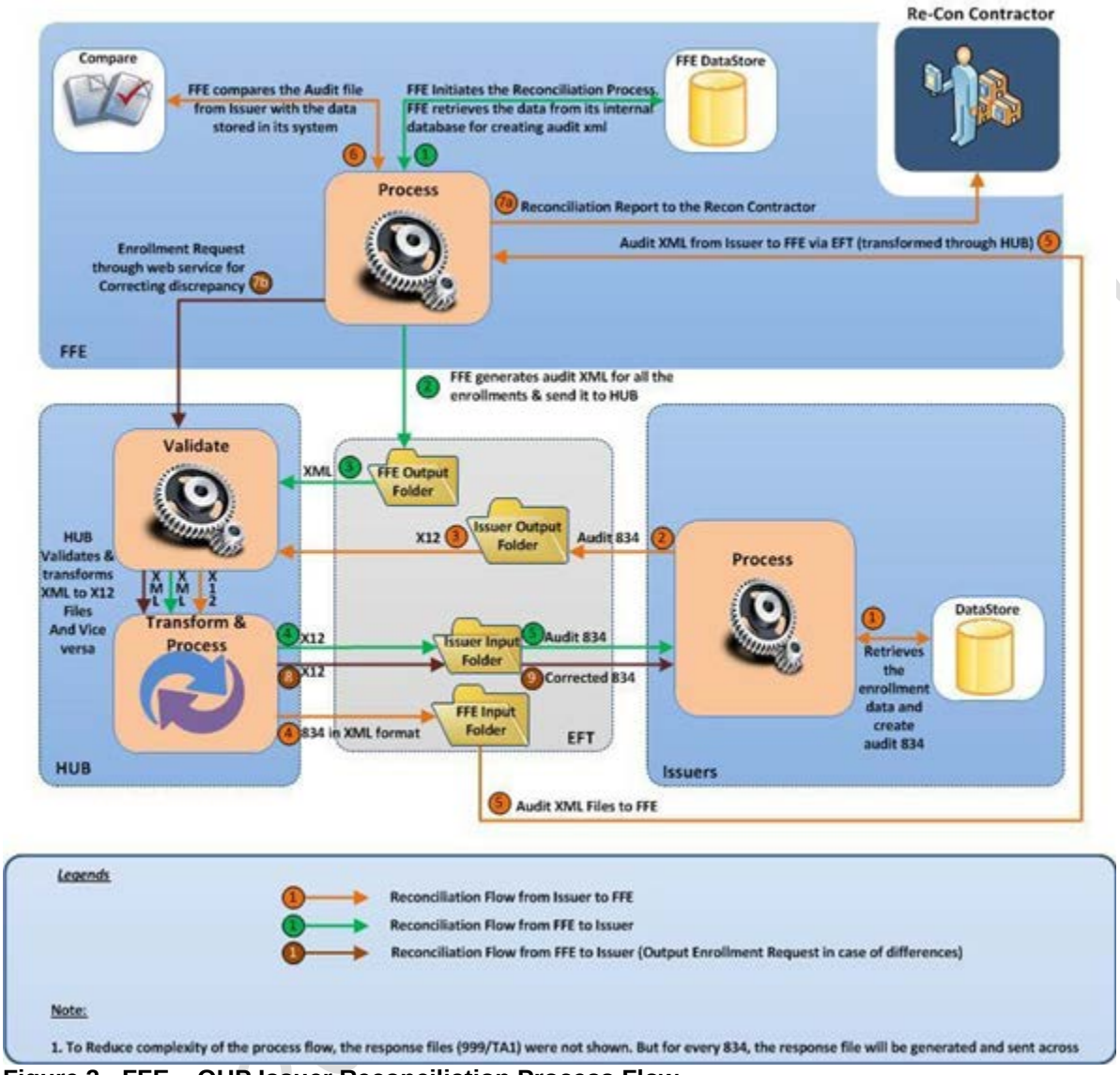


Figure 2 - FFE – QHP Issuer Reconciliation Process Flow

10.7.2 Transaction Element Specific Requirements, SBE to the Department of Health and Human Services (HHS)

At this time there is no supplemental instruction information for transactions from a SBE to the Department of Health and Human Services (HHS). The SBE enrollment data sent to HHS will be stored in the Federal Exchange Program System (FEPS) Enrollment Data Store (EDS). There are no differences between the 834 transactions shared between the FFE and QHP Issuers and those of the SBE and FEPS.

10.7.3 Reconciliation File - SBE to the HHS

The exchange rule requires that a QHP Issuer reconcile enrollment files with the Exchange no less than once a month and that the exchange reconcile enrollment information with QHP

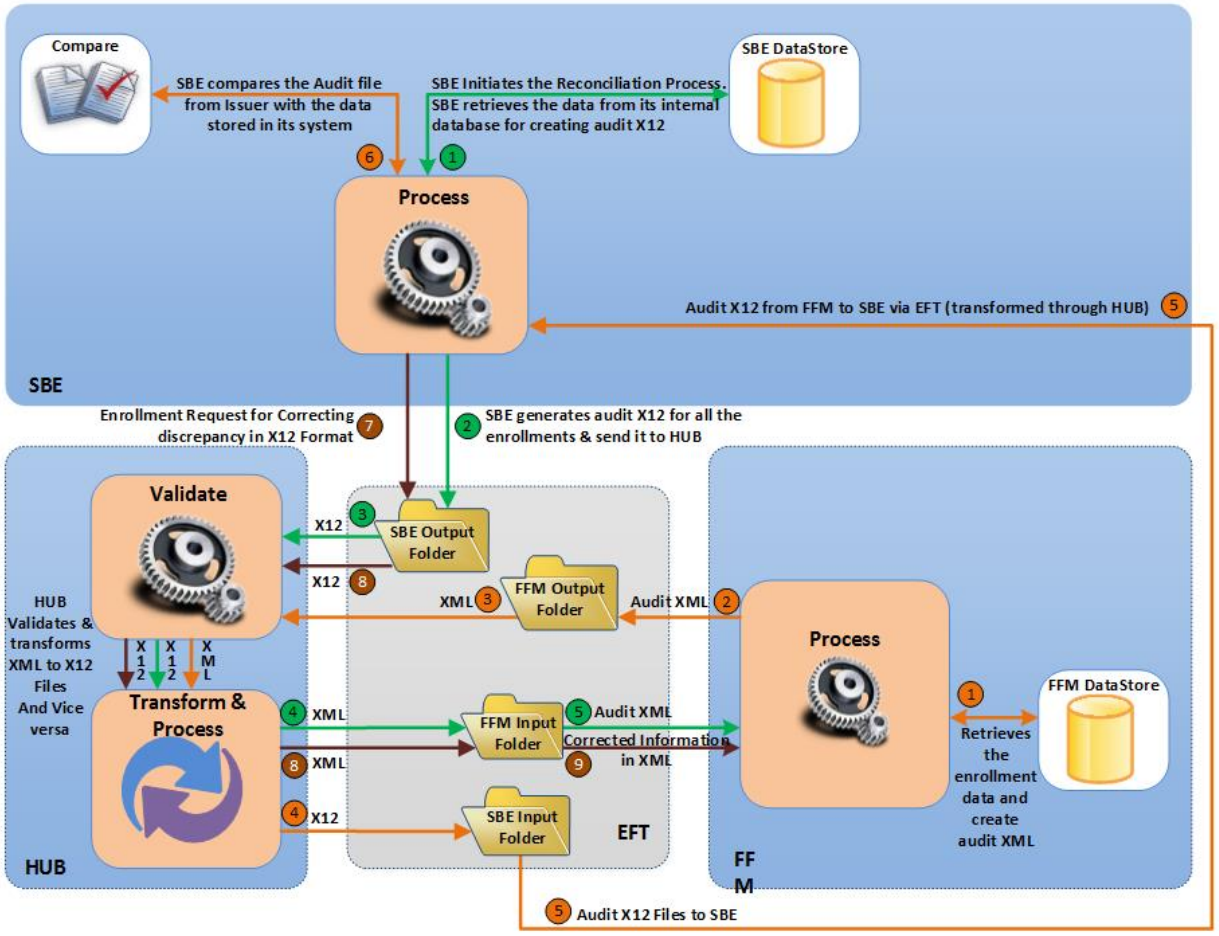
Issuers and HHS no less than on a monthly basis. The SBE will complete the monthly enrollment reconciliation process with QHP Issuers before initiating monthly enrollment reconciliation processes with HHS. The SBE will have completed all daily operational activities related to enrollment before initiating monthly reconciliation with HHS.

Next membership information will be extracted from FEPS and formatted into the appropriate internal XML schema in order to compare the translated inbound 834 monthly enrollment transaction file received from the SBE. Both files must contain enrollment information based upon the same selection criteria. The information from the two files will then be compared. The comparison process will produce a list of discrepancies (aka delta information, or differences). This information will then be made available to the FFE Reconciliation Contractor for follow-up.

The SBE has the ability to perform the same function within their own operating environment by comparing the data received from the HHS and their own extracted data. The differences or delta can then be confirmed with the FFE Reconciliation Contractor. Figure 3 outlines the overall flow for the SBE and the HHS Monthly Reconciliation process.

Reconciliation Process Flow

SBE - FFM



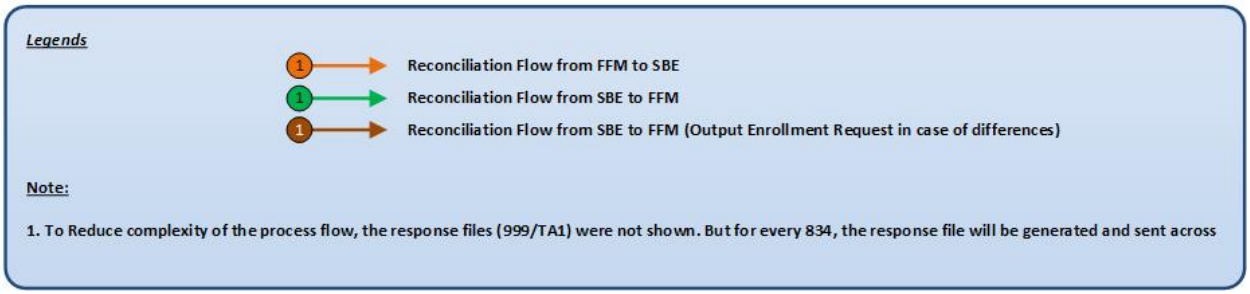


Figure 3 - SBE- DSH Reconciliation Process Flow

Appendix A Glossary of Terms, Acronyms, and Definitions

Table 24 provides terms, acronyms, and associated definitions for terms and acronyms in this document.

Table 24 - Glossary of Terms, Acronyms, and Definitions

Term/Acronym	Definition
ACA	Affordable Care Act
APTC	Advance Payments of the Premium Tax Credit
ASC	Accredited Standards Committee
Assigned Qualified Health Plan Identifier (QHP)	The Assigned Qualified Health Plan Identifier is the Standard Component Identifier plus the Variation Component. The Standard Component ID generated by CMS is a 14 characters(alphanumeric): • A five digit Issuer ID • Two character State ID • Three digit Product Number • Four digit Standard Component Number An example is as follows: 12345VA0020021 The Variant Component ID is 2 characters (Numeric) with the following values and description • 00 - Non-Exchange variant • 01 - Exchange variant (no CSR) • 02 - Open to Indians below 300%FPL • 03 - Open to Indians above 300%FPL • 04 - 73% AV Level Silver Plan CSR • 05 - 87% AV Level Silver Plan CSR • 06 - 94% AV Level Silver Plan CSR Assigned Qualified Health Plan Identifier is a concatenation of the 2. An example of both the Plan Id and Variant Component ID is as follows: 12345VA002002104
Cancellation of Health Coverage	Termination of health coverage PRIOR to the effective date of the health coverage. The enrollee requests that the health coverage they previously selected is cancelled prior to the first possible effective date. (Cancellation = Prior to effective date of coverage Termination = After effective date of coverage)
CCIIO	Center for Consumer Information and Insurance Oversight
CG	Companion Guide

Term/Acronym	Definition
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
Advance CSR	Advance Cost-sharing Reduction Payment
DHHS	Department of Health and Human Services
EDI	Electronic Data Interchange
EDS	Enrollment Data Store
EFT	Enterprise File Transfer
FEPS	Federal Exchange Program System
FF-SHOP	Federally Facilitated Small Business Health Option Program
FFE	Federally Facilitated Exchange HHS operates
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
Hub	Data Services Hub Referred to as the Hub
IG	Implementation Guide
PHS	Public Health Service
QHP	Qualified Health Plan
MEC	Minimum Essential Coverage
Member	The employee will designate any additional Members in the FF-SHOP environment. The Member information will be determined during the Application process in the Individual Market. The Member in the Individual and the FF-SHOP environments will be located in the 2100A NM1 segment with a value of “IL” in NM101 and identified in INS01 with a value of “N”.
Race and Ethnicity Crosswalk	The FFM application will crosswalk the information from the on-line application to the 834 Enrollment transaction
SBE	State Based Exchange State operates all Exchange activities
SFTP	Secure File Transfer Protocol
SHOP	Small Business Health Option Program
Subscriber	The employee will always be the Subscriber in the FF-SHOP environment. The Subscriber will be determined during the Application process in the Individual Market. The Subscriber in the Individual and the FF-SHOP environments will be located in the 2100A NM1 segment with a value of “IL” in NM101 and identified in INS01 with a value of “Y”.

Term/Acronym	Definition
Termination of Health Coverage	Terminate (end-date) health coverage after the health coverage effective date. (Cancellation = Prior to effective date of coverage Termination = After effective date of coverage)
Companion Guide Technical Information (TI)	The Technical Information (TI) section of the ASC X12 Template format for a Companion Guide which supplements an ASC X12 Technical Report Type 3 (TR3)
TR3	Type 3 Technical Report
XOC	eXchange Operational Support Center

Appendix B - Referenced Documents

Table 25 - Referenced Documents lists documents and standards this document references or that are applicable to the development of this document.

Table 25 - Referenced Documents

Document Name	Document Number and/or URL	Date
Assuring Access to Affordable Coverage - Medicaid and the Children's Health Insurance Program Final Rule	http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidCHIP-Eligibility-Final-Rule-Fact-Sheet-Final-3-16-12.pdf	March 16, 2012
Making Documents Section 508 Compliant	http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508/index.html	April 26, 2012
Patient Protection and Affordable Care Act	http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf	March 23, 2010
Plain Writing Act of 2010	http://www.plainlanguage.gov/	April 13, 2011
U.S. Government Printing Office (GPO) Style Manual (30th Edition)	http://www.gpoaccess.gov/stylemanual/browse.html	2008

Appendix C – FFE Change in Circumstance (CiC)

Members are expected to keep the demographic details of their application current. Updates are initiated through www.healthcare.gov. Some changes will result in a CiC while others do not. An 834 will only be sent to an Issuer in cases that result in a Special Enrollment Period (SEP). When a member updates information that does not result in a SEP the member should provide the updated information both through the website mentioned above as well as directly to the Issuer.
There are several life events that result in a SEP Eligibility. They are as follows:

- Adding a member (e.g. birth, marriage, etc.)
- Relocation to a new zip code, county, or state
- Losing access to the other coverage (e.g. employer coverage)
- Release from incarceration
- Changes to citizenship or immigration status

There are several events that will not result in SEP Eligibility. They are as follows:

- Removing a member (e.g. death, divorce, etc.)
- Gaining access to other coverage (e.g. employer coverage)
- Becoming pregnant
- Change in tax filing status/tax household composition
- Change in status as an AI/AN or Tribal Status
- Change in disability status
- Correction to date of birth (DOB) or SSN
- Increase or decrease in income that does not result in an SEP

When a CiC has been completed via the FFM in which the member remains with the same Issuer/QHP the cancelation transaction and the enrollment transaction will be sent to the issuer in the *same* functional group (GS/GE). When a CiC has been completed via the FFM in which the member remains with the same issuer but will change the plan/product the cancelation and enrollment transactions will be sent to the issuer in *separate* functional groups (GS/GE).

The file naming convention for the outbound file from CMS will contain CIC in the function code segment. An example file name is 1234567890.**CIC**834.D130223.T145543452.P.OUT. Issuers will process the CiC 834 and respond back with a TA1/999 as well as effectuate and send back an 834 for normal processing.

Effective dates for CiC are set based off the date of the attestation. If the attestation of the event is prior to the 15th of the current month eligibility will be effective the 1st of the following month. If the attestation of the event is after the 15th of the current month the eligibility will be effective the 1st of the second following month. A complete listing is below.

Table 26 – TERMCIC/CIC for policies with effective dates in the past

SEPs	SEP End Date =		Eligibility Start Date =		Determine Best SEP		
	Qualifying Event Date < 2/6/2014*	Qualifying Event Date >= 2/6/2014*	Reported Date (current date) <= 15th of Current Month	Reported Date (current date) > 15th of Current Month	Effective Date is Retroactive	Effective Date is 1st of Following Month	Effective Date is 1st of 2nd Following Month
Birth, adoption, foster care							
Birth			*Date of Birth*	*Date of Birth*	x		
Adoption			*Date of Adoption*	*Date of Adoption*	x		
Foster Care			*Date of Foster Care*	*Date of Foster Care*	x		
Death of Member			*Date of Death*	*Date of Death*	x		
Death of Subscriber			*Not Supported*	*Not Supported*			
Marriage			1st of following month	1st of following month		x	
Loss of MEC/Medicaid Denied							
Past	2/6/14* + 60 days	Qualifying Event Date + 60 days	1st of following month	1st of 2nd following month		x	
Future			*1st of month after loss date*	*1st of month after loss date*		x	
PTC/CSR (not for CiC 1)			1st of following month	1st of 2nd following month			x
Relocation			1st of following month	1st of 2nd following month			x
Release from Incarceration			1st of following month	1st of 2nd following month			x
HHS Involvement (not for CiC 1, 2)			*Date of HHS Action*	*Date of HHS Action*	x		
Gain citizenship or eligible immigration			1st of following month	1st of 2nd following month			x
Indian Status			1st of following month	1st of 2nd following month			x
Decertification (not for CiC 1, 2)			1st of following month	1st of 2nd following month			x
	* = Deployment Date + 3 days						

Table 27 – CANCELCIC/CIC for policies with effective date in the future

SEPs	SEP End Date =		Eligibility Start Date =		Determine Best SEP		
	Qualifying Event Date < 2/6/2014*	Qualifying Event Date >= 2/6/2014*	Reported Date (current date) <= 15th of Current Month	Reported Date (current date) > 15th of Current Month	Effective Date is Retroactive	Effective Date is 1st of Following Month	Effective Date is 1st of 2nd Following Month
Birth, adoption, foster care							
Birth			*Policy Effective Date*	*Policy Effective Date*		x	
Adoption			*Policy Effective Date*	*Policy Effective Date*		x	
Foster Care			*Policy Effective Date*	*Policy Effective Date*		x	
Death of Member			Policy Effective Date	Policy Effective Date		x	
Death of Subscriber			Policy Effective Date	Policy Effective Date		x	
Marriage			1st of following month	1st of following month		x	
Loss of MEC/Medicaid Denied							
Past	2/6/14* + 60 days	Qualifying Event Date + 60 days	1st of following month	1st of 2nd following month		x	
Future			*1st of month after loss date*	*1st of month after loss date*		x	
PTC/CSR (not for CiC 1)			1st of following month	1st of 2nd following month			x
Relocation			1st of following month	1st of 2nd following month			x
Release from Incarceration			1st of following month	1st of 2nd following month			x
HHS Involvement (not for CiC 1, 2)			*Date of HHS Action*	*Date of HHS Action*	x		
Gain citizenship or eligible immigration			1st of following month	1st of 2nd following month			x
Indian Status			1st of following month	1st of 2nd following month			x
Decertification (not for CiC 1, 2)			1st of following month	1st of 2nd following month			x
	* = Deployment Date + 3 days						

Table 28 – 834 Supplemental Instructions for FFE to QHP Issuer handling of CIC

Loop	Reference	Name	Code/Value	Exchange Instruction
2000		Member Level Detail		
2000	INS03	Maintenance Type Code	024	This will be used within the Cancelation and Termination transactions
2000	INS03	Maintenance Type Code	021	This will be used within the Enrollment transaction
2750		Reporting Category		
2750	N102	Reporting Category	"ADDL MAINT REASON"	
2750	REF01	Reference Identification Qualifier	17	

Loop	Reference	Name	Code/Value	Exchange Instruction
2750	REF02	Reference Identification	“CANCELCIC”	Use within the Cancelation transaction when the effective date is >= event date
2750	REF02	Reference Identification	“TERMCIC”	Use within the Cancelation transaction when the effective date is < the event date
2750	REF02	Reference Identification	“CIC”	Used within the Enrollment transaction identifying the ‘new’ policy is a result of CIC.
2750		Source Exchange ID		
2750	N102	Reporting Category	“SOURCE EXCHANGE ID”	
2750	REF01	Reference Identification Qualifier	17	
2750	DTP03	Date/Time Range		The effective date within the Termination/Cancelation file should equal the system date.

Appendix D - Record of Changes

Table 29 - Record of Changes

Version	Date	Revision/Change Description
1.7	05/16/2014	Section 4.1.2 – Updated ST control number - must be numeric
1.7	05/16/2014	Section 7.1:Table 2 – Corrected security information reference to ISA03
1.7	05/16/2014	Section 9.1:Table 4 – Added clarifying note for 1L
1.7	05/16/2014	Section 9.2 – Removed incorrect information from last bullet
1.7	05/16/2014	Section 9.3 – Added Communication Contact information for FF-SHOP
1.7	05/16/2014	Section 9.5.1:Table 7 and Table 8 Clarified information for Other Payer Amounts Added OTH PAY AMT 2 to the Total Responsibility Amount Calculation
1.7	05/16/2014	Section 9.6.1:Table 10 -Added TERM-DCT to ADDL MAINT REASON
1.7	05/16/2014	Section 9.6.1:Table 11 PRE AMT 1 - Removed note for Family rated SOURCE EXCHANGE ID- Added usage for CANCEL and TERM Information added for APPLICATION ID AND ORIGIN SEP REASON – Removed used for CHG transactions
1.7	05/16/2014	Section 9.6.2: Corrected included examples for FF-SHOP
1.7	05/16/2014	Section 9.6.2:Table 12 PRE AMT 1 - Removed note for Family rated Information added for APPLICATION ID AND ORIGIN SEP REASON – Removed used for CHG transactions
1.7	05/16/2014	Section 9.6.2:Table 13 and Table 14 Updated SEP REASON CODES and Examples for FF-SHOP
1.7	05/16/2014	Section 10.1:Table 17 – Initial Enrollment Added FF-SHOP specific details Added FF-SHOP specific codes Removed elements where no exchange specific instruction is needed Clarified instruction where needed
1.7	05/16/2014	Section 10.2:Table 18 – Confirmation/Effectuation Removed rows where no exchange specific instruction needed Added FF-SHOP specific enrollment instructions Added FF-SHOP specific codes
1.7	05/16/2014	Section 10.3 – Updated to clarify differences between FF-SHOP and Individual market. Clarified information sent in the Member Policy

Version	Date	Revision/Change Description
1.7	05/16/2014	Section 10.3: Table 19 – Cancellation Added FF-SHOP specific details Added FF-SHOP specific codes Added instructions for including the Member Policy Number Included expected code for Member DTP
1.7	05/16/2014	Section 10.4 Clarify differences between FF-SHOP and Individual market for non-payment Clarified information sent in the Member Policy
1.7	05/16/2014	Section 10.4: Table 20 – Termination of Enrollment Group Added FF-SHOP specific details Added FF-SHOP specific codes Added instructions for including the Member Policy Number Included expected code for Member DTP Added ADDL MAINT REASON details
1.7	05/16/2014	Section 10.5 Added FF-SHOP
1.7	05/16/2014	Section 10.5: Table 21 – Termination of Individual Added FF-SHOP specific details Clarification instructions Added ADDL MAINT REAONS details
1.7	05/16/2014	Section 10.6.2: Table 23 - Reinstatement Added maintenance type codes Corrected employment status codes
1.7	05/16/2014	Section 10.6.3 – Updated section
1.7	05/16/2014	Section 10.6.4 – FF-SHOP only
1.7	05/16/2014	Section 10.6.5 – FF-SHOP only
1.7	05/16/2014	Section 10.7 – Monthly Reconciliation File Processes This section has been deleted
1.7	05/16/2014	Appendix C – FFE Change in Circumstance (CiC) This appendix has been added

Appendix E - Approvals

Table 30 - Approvals

Document Approved By	Date Approved
Name: First Name Last Name, Team Lead/Team Manager	Date